APPENDIX

KENTUCKY BOARD OF NURSING
4010 DUPONT CR.-Suite 430
Louisville, Kentucky 40207
(502) 897-5143

OPINION

Roles of Nurses in Intravenous Therapy Practice

The primary mission of the Kentucky Board of Nursing, performed through the regulation of nurses and nursing education and practice, is to protect the public, and to assure that safe and effective nursing care is provided by nurses for the citizens of the Commonwealth. In order to protect and safeguard the health and safety of the citizens who receive intravenous therapy and to address the numerous inquiries relative to the scope of nursing practice in intravenous therapy/procedures, it is necessary to define the appropriate roles of nurses in intravenous therapy practice.

Numerous inquiries regarding intravenous therapy practice have been received by the Board. The minutes of the past Kentucky Board of Nursing meetings document that there has been ongoing study of the roles of nurses in intravenous therapy practice and that the Board has issued opinions relative to this matter since 1976. In June, 1982, the Board constituted a Practice Committee, composed of persons representing various areas of the Commonwealth and various kinds of nursing practice settings, to study and make recommendations regarding the appropriate roles of nurses in intravenous therapy practice. The Practice Committee's research of this issue included extensive review of standards of nursing practice, curricula of Board approved nursing education programs in the Commonwealth, and laws governing nursing practice. Relevant sections of the Kentucky Revised Statutes Chapter 314 (Kentucky Nursing Practice Act) include the following:

Section 314.011(5) "Registered nursing practice" shall mean the performance of acts requiring substantial specialized knowledge, judgment and nursing skill based upon the principles of psychological, biological, physical and social sciences in the application of the nursing process in:

a) the care, counsel and health teaching of the ill, injured or infirm.

b) the maintenance of health or prevention of illness of others.

c) the administration of medication and treatment as prescribed by a physician or dentist licensed in this state and as further authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.

d) the supervision and teaching of other personnel in the performance of activities relating to nursing care.

e) the performance of other nursing acts which are authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.

Section 314.011(9) "Licensed practical nursing practice" shall mean the performance of acts requiring the knowledge and skills such as - are taught or acquired in approved schools for practical nursing in:

a) the observing and caring for the ill, injured or infirm under the direction of a registered nurse, a licensed physician or dentist.

b) the giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the Board.

c) the administration of medication or treatment as authorized by a physician or dentist licensed in this state and as further authorized or limited by the Board which are consistent with the National Federation of Licensed Practical Nurses or with standards of practice established by nationally accepted organizations of licensed practical nurses.

d) teaching or supervising except as limited by the Board.

e) the performance of other nursing acts which are authorized or limited by the Board and which are consistent with the National Federation of Licensed Practical Nurses' standards of practice established by nationally accepted organizations of licensed practical nurses.

Section 314.011(11) "Continuing education" shall mean participation in approved offerings beyond the basic nursing education program that present specific content planned and evaluated to meet competency based behavioral objectives which develop new skills and upgrade knowledge.

Section 314.021(2) All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience in nursing.

In accordance with these sections of KRS Chapter 314 and after study of the issue, the Practice Committee identified three categories of intravenous therapy practice. After review of the Practice Committee's study and recommendation, it was the opinion of the Board that the practice of the registered nurse and the licensed practical nurse be guided by the three categories as herein defined.

Category I: Because of the knowledge and skills acquired in approved programs for practical nursing, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved practical nursing program and licensure and under the supervision* of a registered nurse, physician or dentist:

1. Perform simple calculation and adjust flow rate.
2. Observe and report subjective and objective signs of adverse reactions to IV administration.
3. Inspect insertion site, change dressing and remove intravenous needle or catheter from peripheral veins except as limited** by the Board.

Category II: Because the curricula taught in approved programs for practical nursing provide the basic background knowledge for the licensed practical nurse to develop new skills and upgrade knowledge through continuing education, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved continuing education course for intravenous therapy/procedures and under the supervision* of a registered nurse, physician or dentist:

1. Perform venipuncture to withdraw blood from peripheral veins except as limited** by the Board.
2. Perform venipuncture to start intravenous fluids in peripheral veins except as limited** by the Board.
3. Perform venipuncture to start the following IV fluids - D_5W, D_5NS, $D_5\frac{1}{2}NS$, $D_5\frac{1}{4}NS$, NS, $\frac{1}{2}NS$, $\frac{1}{4}NS$ in peripheral veins except as limited** by the Board.
4. Hang the following IV fluids - D_5W, D_5NS, $D_5\frac{1}{2}NS$, $D_5\frac{1}{4}NS$, NS, $\frac{1}{2}NS$, $\frac{1}{4}NS$ to pre-existing venipunctures in peripheral veins except as limited** by the Board.
5. Change IV administration set except as limited** by the Board.

Category III: The registered nurse may perform all procedures in Categories I and II. Because the basic curricula taught in approved programs for registered nursing include the in-depth application of principles of psychological, biological, physical and social sciences for the performance of those acts requiring substantial specialized knowledge, judgment and nursing skills, only the registered nurse may perform, but is not limited to, the following intravenous procedures:

1. Hang blood or blood components.

2. Hang solution for intravenous parenteral nutrition, e.g. hyperalimentation or similar solution.

3. Administer medication via intravenous route:

   a. Add medication to an intravenous solution.

   b. Hang piggy back infusions.

   c. Inject medication into an auxillary fluid chamber, e.g. volutrol, buretrol.

   d. Inject medication via direct intravenous route, e.g. bolus, push.

4. Flush or aspirate an IV line, arterial line, needle or catheter.

5. Change dressing, IV administration set or remove an intravenous cannula from the following: femoral, subclavian, or jugular vein, any venous or arterial site in which a central line is inserted or any arterial site or cut-down site.

6. Change dressing, IV administration set or remove an intravenous cannula when the peripheral cannula must remain in place for prolonged periods (>72 hours) or the patient has an unexplained fever and/or there is pain or tenderness at the site of insertion, or other signs of cannula related infection, phlebitis or other complications from IV administration.

*"Supervision" shall mean immediately available to assess and evaluate patient response(s) and to assess, direct and evaluate nurse performance.

**"Except as limited" shall mean the specified IV procedure shall not be performed when the following sites/procedures are used for IV administration: femoral, subclavian or jugular vein; any peripheral vein in which a central line is inserted, any arterial site/line, any central line insertion procedure or cut-down procedure.

Effective July 1, 1984.

as

DESCRIPTION OF KENTUCKY

ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS

THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed and the Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS 311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES
OFFICE OF GENERAL COUNSEL
APRIL 22, 1991

Living Will Declaration

APPENDIX XIX

Declaration made this _____ day of _____(month), _____ (year). I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending and one (1) other physician in their discretion, have determined such condition is incurable and irreversible and will result in death within a relatively short time, and where the application of life-prolonging treatment would serve only to artificially prolong the dying process, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain or for nutrition or hydration.

In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration shall be honored by my attending physician and my family as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

State of Kentucky)
)Sct.
County of _____)

Before me, the undersigned authority, on this day personally appeared _____, Living Will Declarant, and _____ and _____, known to me to be witnesses whose names are each signed to the foregoing instrument, and all these persons being first duly sworn, _____, Living Will Declarant, declared to me and to the witnesses in my presence that the instrument is the Living Will Declaration of the declarant and that the declarant has willingly signed and that such declarant executed it as a free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence and hearing of the Living Will Declarant, that the declarant signed the declaration as witnessed, and to the best of such witnesses' knowledge, the Living Will Declarant was eighteen(18) years of age or over, of sound mind and under no constraint or undue influence.

_____
Living Will Declarant

_____
Witness

_____
Address

_____
Witness

_____
Address

Subscribed, sworn to and acknowledged before me by _____, Living Will Declarant, and subscribed and sworn before me by _____ and _____, witnesses, on this the _____(day) of _____(month), _____(year).

APPENDIX XX

DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S) TO MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY. IF _____ REFUSES OR IS NOT ABLE TO ACT FOR ME, I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S).

ANY PRIOR DESIGNATION IS REVOKED.

SIGNED THIS _____ DAY OF _____, 19_____

_____

SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED AND SIGNED FOR THE GRANTOR.

_____

SIGNATURE AND ADDRESS OF WITNESS

_____

SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

_____ COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS _____ DAY OF _____, 19_____

_____

SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: _____

ADVANCE DIRECTIVE

ACKNOWLEDGMENT

NAME: _____ DATE OF BIRTH: _____

SOC. SEC.#: _____

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your initials after <u>each</u> statement.

1. I have been given written materials about my right to accept or refuse medical treatment. _____(Initialed)
2. I have been informed of my right to formulate advance directives. _____(Initialed)
3. I understand that I am not required to have an advance directive in order to receive medical treatment. _____(Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permitted by law. _____(Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. _____(Initialed)

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING STATEMENTS:

☐ I HAVE EXECUTED AN ADVANCE DIRECTIVE.

☐ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

_____ DATE: _____
Patient/Guardian

_____ DATE: _____
Health Care Provider Representative

PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED HEALTH CARE PROVIDERS

1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.

2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.

3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.

4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.

5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.

6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.

PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Purpose:

1. To assure individuals understand they have the right to:
    a. Accept or refuse medical or surgical treatment; and
    b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Designate a person or persons responsible for informing adult patients of their right to make decisions concerning their medical care.
2. Distribute to each adult patient the following information:
    a. The Cabinet for Human Resources ' description of Kentucky Laws on Advance Directives.
    b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

"Advance Directives Issues and Answers"
Hospice of the Bluegrass

"Advance Directives, Living Will, Health Care Surrogate, Durable Power of Attorney" Video
Hospice of the Bluegrass

"About Advance Medical Directives"
Channing Bete Co., Inc.

"Living Will"
Division of Aging Services

PATIENT SELF-DETERMINATION (Continued)

"Planning For Difficult Times - Tomorrow's Choices"
"Planning For Difficult Times - A Matter of Choice"
American Association of Retired Persons

3. Maintain *Living Will* and *Designation of Health Care Surrogate* documents for distribution to adult patients upon request.

4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.

5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend use of attached *Advance Directive Acknowledgment* Form.) A process shall be developed to assure appropriate staff are advised of the patient's directive.

6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.

7. Stipulate by policy, family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.

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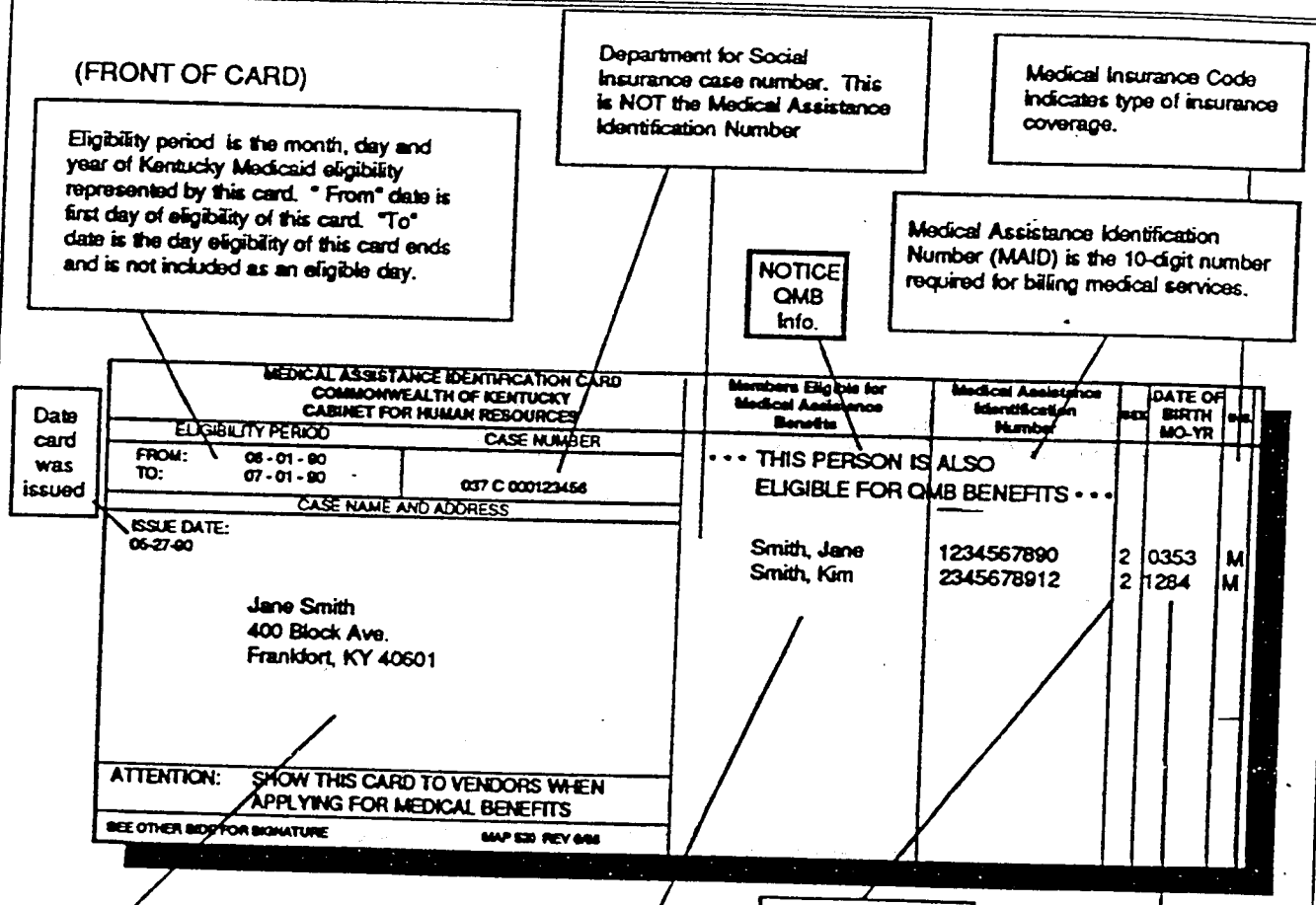
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-B

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

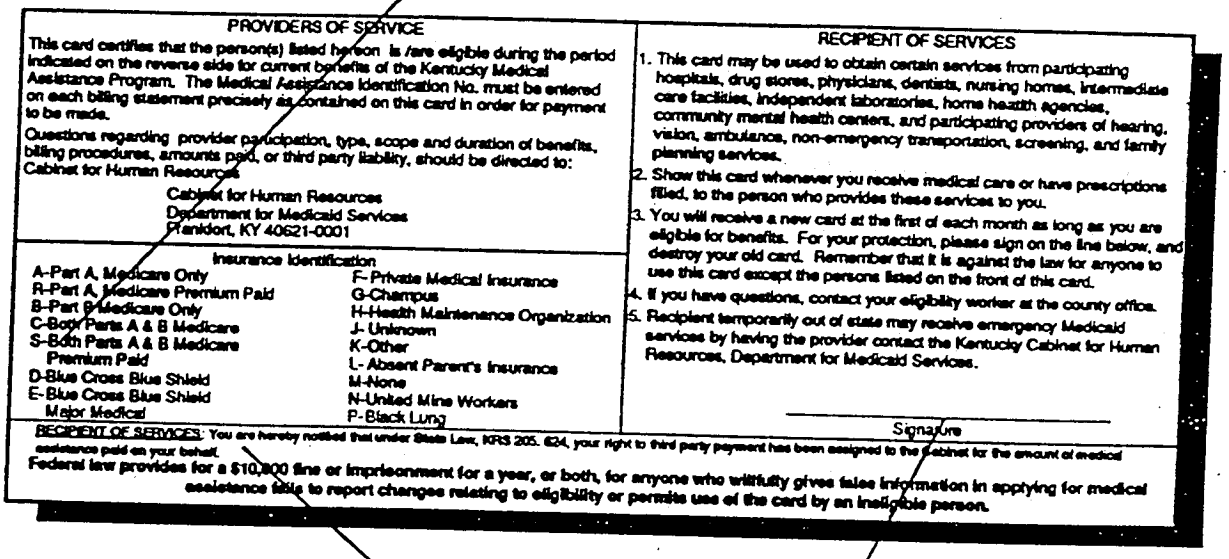


WHITE CARD (ALSO)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



PROVIDERS OF SERVICE

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621-0001

Insurance Identification

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205. 624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-C

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(FRONT OF CARD)

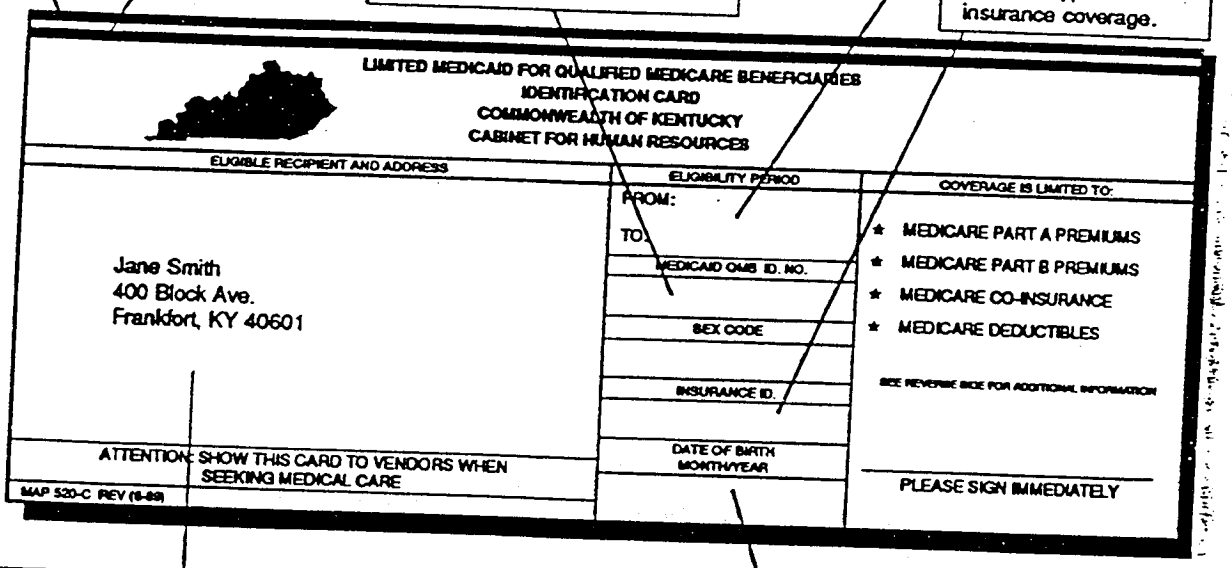
Eligibility period is the month, day and year of QMB eligibility represented by this card.
" From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Red

Blue

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Medical Insurance Code indicates type of insurance coverage.



Name of member eligible to be a Qualified MedicareBeneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

RED, WHITE, AND BLUE CARD

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE

1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-Insurance and Deductables only.
2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621-0001

Insurance Identification

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F- Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J- Unknown
K-Other
L- Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

RECIPIENT OF SERVICES

1. Show this card whenever you receive Medical Care.
2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.
3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
4. If you have questions, contact your case worker at the Department for Social Insurance County office.

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-D

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(FRONT OF CARD)

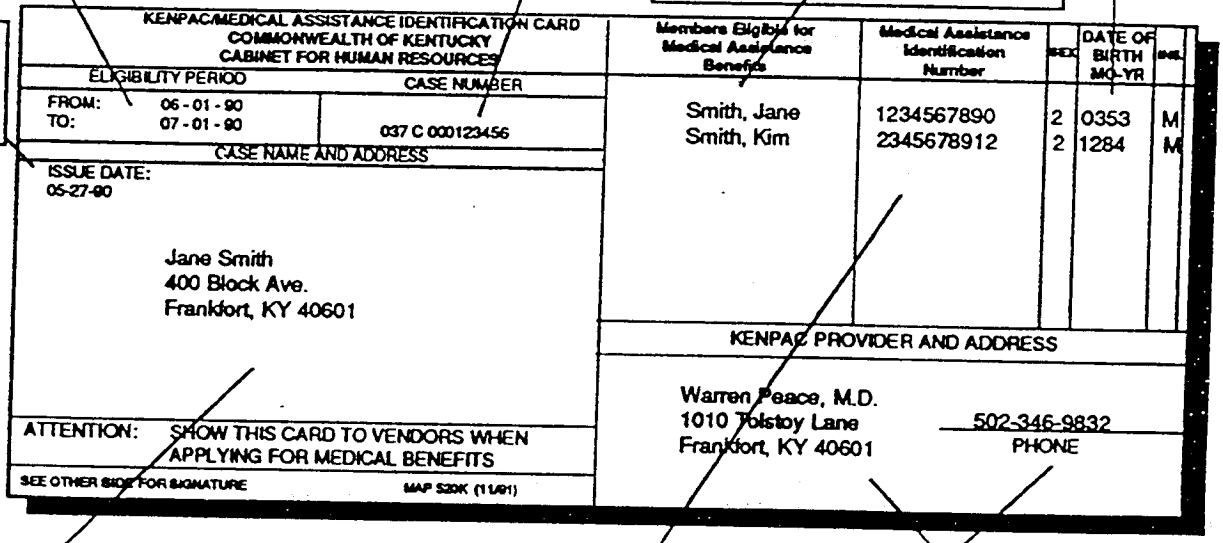
Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care provider listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for Kentucky Medicaid. Persons whose names are in this block have the Primary Care provider listed on this card.

Date card was issued



Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care provider.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

GREEN CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

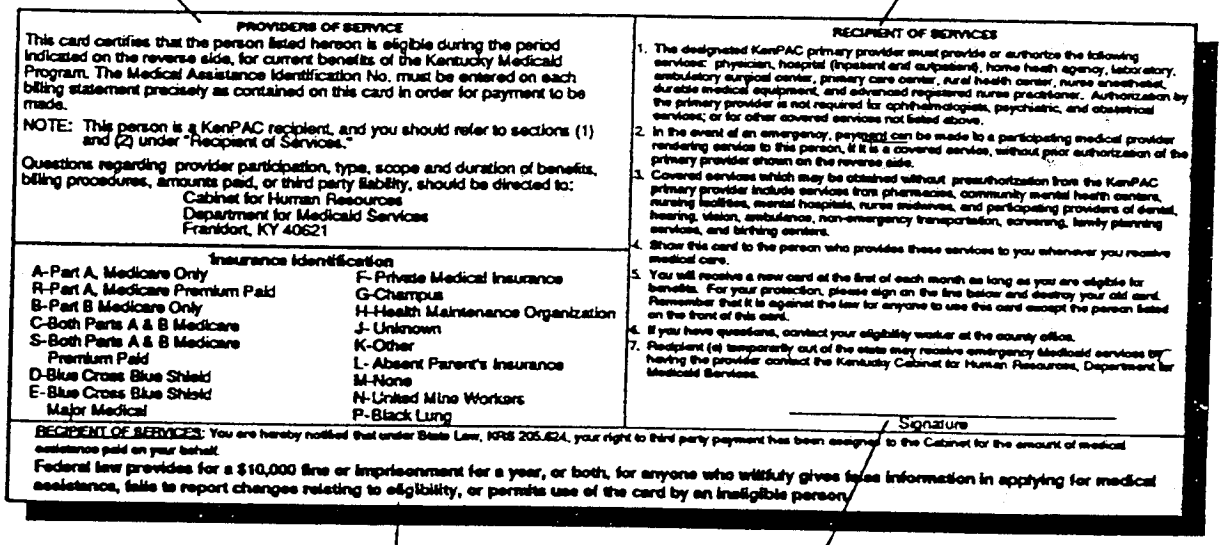
APPENDIX II-D

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.



PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medicaid Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

Insurance Identification

A-Part A, Medicare Only	F-Private Medical Insurance
R-Part A, Medicare Premium Paid	G-Champus
B-Part B Medicare Only	H-Health Maintenance Organization
C-Both Parts A & B Medicare	J- Unknown
S-Both Parts A & B Medicare Premium Paid	K-Other
	L- Absent Parent's Insurance
D-Blue Cross Blue Shield	M-None
E-Blue Cross Blue Shield Major Medical	N-United Mine Workers
	P-Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and outpatient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, nurse anesthetist, durable medical equipment, and advanced registered nurse practitioner. Authorization by the primary provider is not required for ophthalmologists, psychiatric, and obstetrical services; or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

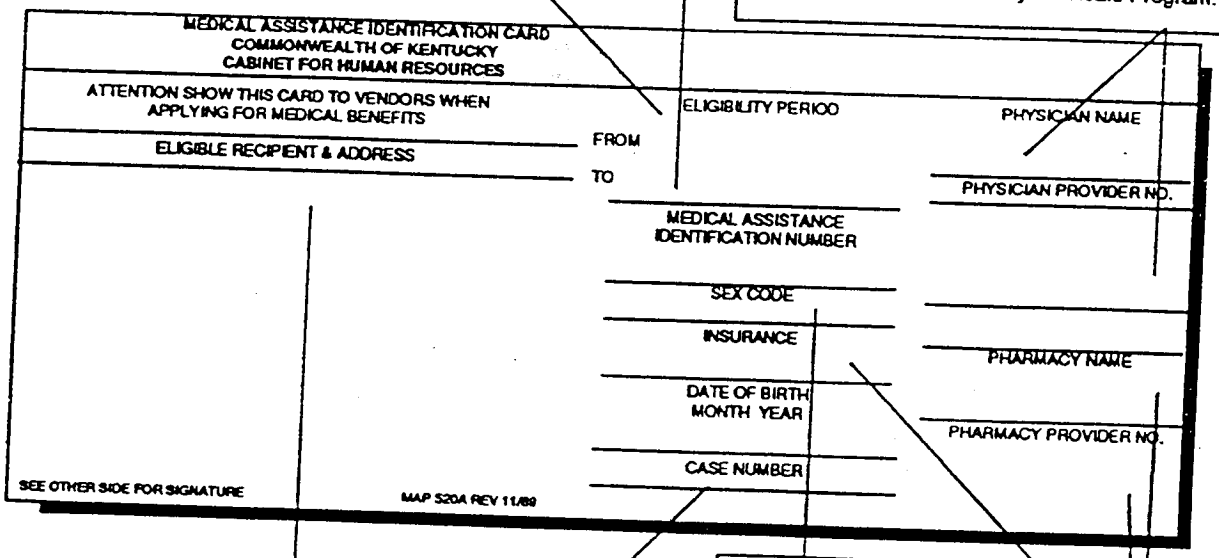
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. Kentucky Medicaid payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the Kentucky Medicaid Program.



Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently Left Blank

Insurance Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

PINK CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. Questions regarding scope of services should be directed to the Lock-In Coordinator by calling 502-564-6560.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A-Part A Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-Unified Mine Workers
P-Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

MAP-343 (Rev. 5/86)

APPENDIX III

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

MAP-343 A
(11/91)

APPENDIX III

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____ (Name) _____ (County)

2. _____ (Location Address, Street, Route No, P.O. Box)

3. _____ (City) (State) (Zip)

4. _____ (Office Phone# of Provider)

5. _____ (Pay to, In care of, Attention, etc. If different from above address.)

6. _____ Pay to address (If different from above)

7. Federal Employee ID No. _____

8. Social Security No. _____

9. License No. _____

10. Licensing Board (If applicable): _____

11. Original license date: _____

12. Kentucky Medicaid Provider No. (If known) _____

13. Medicare Provider No. (If applicable) _____

14. Practice Organization/Structure: _____ (1) Corporation
_____ (2) Partnership ____(3) Individual
_____ (4) Sole Proprietorship ____ (5) Public Service Corporation
_____ (6) Estate/Trust ____ (7) Government/Non-Profit

15. Are you a hospital based physician (salaried or under contract by a hospital)? ____ yes ____ no
Name of hospital(s) _____

16. If group practice, number of providers in group (specify provider type):

_____

17. If corporation, name, address, and telephone number of corporate office:

_____

_____

Telephone No: _____

Name and address of officers:

_____

_____

_____

_____

18. If partnership, name and address of partners:

_____

_____

_____

_____

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:

___ Federal ___ State ___County ___City

___ Charitable or religious

___ Proprietary (Privately-owned) ___ Other

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

_____

_____

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:

_____

Member: _____

Member: _____

30. Management Firm (If applicable):

_____

31. Lessor (If applicable):

_____

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership

34. Institutional Review Committee Members (If applicable):

_____

_____

35. Providers of Transportation Services:
Number of Ambulances in Operation:____
Number of Wheelchair Vans in Operation: ____
Basic Rate $_____ (Includes up to ___ miles)
Per Mile $_____ Oxygen $_____
Extra Patient $_____ Other $_____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? ____ yes ____ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

MAP-246 (Rev. 04/91)

APPENDIX IV

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____, to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

Date: _____

Contact Name: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

_____
Signature, Representative of the
Department for Medicaid Services

Date: _____

MAP-380 (Rev. 04/90) APPENDIX V

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____ (Name and Address of Provider), hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____ (Type of Provider and/or Level of Care), _____ (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY: _____
Signature of Provider

Contact Name: _____

Title: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Authorized Official
or Designee

Name: _____

Title: _____

Date: _____

MAP-34
11/87

APPENDIX VI

Commonwealth of Kentucky
Cabinet for Human Resources
Department for Medicaid Services

HOME HEALTH AGENCY CERTIFICATION

_____ (Name of Agency)

_____ (Name of Patient)

_____ (Vendor #)

_____ (County)

Date of Service _____ (Month) _____ (Year)

_____ (City)

_____ (State)

This document serves to certify that benefits for Home Health Agency services have been utilized to the full extent of Title XVIII benefits under Part A and Part B and that the request for Program payment represents the Home Health Agency Services provided after exhaustion of benefits available under Title XVIII for the above-referenced program recipient.

I certify the above information is true, complete and correct to the best of my knowledge and belief.

Rejected by Title XVIII (Provide explanation in space to the right of the box) ☐ Explanation: _____

Rejected by Utilization Review Mechanism (Provide explanation in space to the right of the box) ☐ Explanation: _____

_____
Authorized Home Health Agency Representative

APPENDIX VII

(REV. 7/91)

THIRD PARTY LIABILITY LEAD FORM

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address: _____

Policy #: _____ Start Date: _____ End Date: _____

Date Filed with Carrier: _____

Provider Name: _____ Provider #: _____

Comments: _____

_____

_____

_____

_____

Signature: _____ Date: _____

APPENDIX VIII

OMB 0938-0277

1	2	3 PATIENT CONTROL NUMBER		4 TYPE OF BILL
5 BC/BS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9
T'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY / STATE / ZIP
12 BIRTH DATE	13 SEX	14 MS	ADMISSION: 15 DATE / 16 HR / 17 TYPE / 18 SRC	19 A H / 20 D H / 21 STAT
22 STATEMENT COVERS PERIOD: FROM / THROUGH	23 COV D	24 N-C D	25 C-I D	26 L-R D / 27
28 OCCURRENCE: CD / DATE	29 OCCURRENCE: CD / DATE	30 OCCURRENCE: CD / DATE	31 OCCURRENCE: CD / DATE	32 OCCURRENCE: CD / DATE
33 OCCURRENCE SPAN: CD / FROM / THROUGH				
34				
CONDITION CODES: 35 / 36 / 37 / 38 / 39	BLOOD RECORD (PINTS): 40 FURN / 41 REPL / 42 NOT RP / 43 DED	44 SP PROG	45	
46 VALUE: CD / AMT	47 VALUE: CD / AMT	48 VALUE: CD / AMT	49 VALUE: CD / AMT	

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56

PAYER	59 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE

MT DT. ▷	DISCH DT ▷	DUE FROM PATIENT ▶

NSURED'S NAME	66 SEX	67 P REL	68 CERT -SSN-HIC -ID NO	69 GROUP NAME	70 INSURANCE GROUP NO

D	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID	75 EMPLOYER LOCATION

INCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN CODE	OTHER DIAGNOSES CODES: 78 / 79 / 80 / 81

83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE: CD / DATE	85 OTHER PROCEDURE: CD / DATE	86 OTHER PROCEDURE: CD / DATE

PSRO UR DATA: APP FROM	Ey APP THROUGH	90 GRC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID

ARKS	VERIFIED N-C STAY DATES: FROM / THROUGH	FOR INTERMEDIARY USE ONLY: PR PSC D	ADM DIAG

AMT REIMBURSED	N PYM CD		APPROV BY	DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

HCFA-1450

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3000000000	9883324-552-580	030192-033192	265.00	10.00	0.00	255.00	365
01 PS 4	PROC/REV 550	QTY 4		030192-033192	240.00	8.00		232.00	365
02 PS 4	PROC/REV 270	QTY 5		030192-033192	25.00	2.00		23.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 265.00 TOTAL PAID: 255.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
023104	JONES R	4000000000	9838348-552-010	030192-033192	60.00	
01 PS 4	PROC/REV 550	QTY 1		030192-033192	60.00	262

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 60.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	200000000	9883342-564-210	030192-033192	120.00	260
574632	MITCHELL J	400000000	9883347-575-240	030192-033192	240.00	260

CLAIMS PENDING IN THIS CATEGORY: 2

TOTAL BILLED: 360.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	EOB
324789	SMITH	5000000000	9883324-552-060	030192-033192	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92
RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY CHECK NUMBER 3286364

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	255.00	0.00	255.00	0.00	48.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

DESCRIPTION OF EXPLAINATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID
262 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BEING MADE
999 REQUIRED INFORMATION NOT PRESENT

APPENDIX X

Rev 5/92

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, KY 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)
2. Provider Name and Address	4. Medical Assistance Number
	5. Billed Amount / 6. Claim Service Date
	7. RA Date / 8. Internal Control Number
9. Provider's Message	

10. _____
Signature Date

ar Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim as indicated above. Please resubmit.

_____ This claim paid on _____ in the amount of _____.

_____ This claim was denied on _____ with EOB code _____.

_____ This claim denied on _____ with EOB 294 "Kenpac Recipient. Referring provider number is missing or is not the Kenpac primary physician/clinic number for the date(s) of service."

_____ This claim denied on _____ with EOB 295 "Kenpac Recipient. Billing and/or referring provider number is not the Kenpac primary physician/clinic for date(s) of service."

_____ This claim denied on _____ with EOB 281 "Recipient has other medical coverage. Bill other insurance first or attach documentation of denial from the insurance carrier."

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

a. When exercising muscle or joint structure the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
b. Progress is shown at predictable intervals.
c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

a. Lacks documented detail of dysfunction or goal.
b. Goal seems unreasonable.
c. Stability of the resident questioned.
d. Participation level is a hinderance.
e. Plateaued, goal achieved, or needs only repetitive ROM for nursing care plan.
f. Persistent flaccidity > 2—4 weeks focused area.

2. Shared Modalities for Physical Therapy

a. Heat therapy.
b. Cold therapy.
c. Prosthesis.
d. Electromyographic biofeedback.

Indication for Denial (see listings for Physical Therapy)

3. Functional Activities of Daily Living

a. Feed.
b. Dress.
c. Bathe.
d. Toileting.
e. Grooming.

11. High Pressure Wound Irrigation

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable effectiveness or superiority to simpler devices.
    c. Nursing can provide equivalent service.

12. Hyperbaric Oxygen Wound Care

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

9. Prosthesis

   a. Candidate has the capacity to use device.
   b. Candidate shows muscular strength, motor control, and range of motion adequate for gainful use.

   Indication for Denial

   a. Unteachable.
   b. Lacks items in 9-a and b.
   c. Poor wound healing.
   d. Other inappropriate conditions (such as bilateral, above-knee amputation over age 45, or below-elbow amputee or flail joint shoulder or elbow).
   e. Repetitive exercises that nursing care plan can accomplish pre—prothesis for stump shrinker use or prosthetic fitting.
   f. Repetitive use for distance or endurance only with level change having been achieved.
   g. Assisting routine care of equipment.
   h. Safety has been established so that the resident can perform trained exercise with supervision by nursing being the only need.

10. Electromyographic Biofeedback

   a. Spasticity or weakness as part of an acute cerebral vascular accident (CVA).
   b. Acute or chronic spinal cord injury.
   c. Multiple sclerosis with mild spasticity.

   Indication for Denial

   a. Absence of reasonable gain in the treatment plan time frame.
   b. Questionable effectiveness for the condition.
   c. Resident lacks voluntary control or motivation.

6. Ultrasound

   a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e., post—hip open reduction internal fixation.
   b. Reduce pain or muscle spasm.
   c. Trigger points.

   Indication for Denial

   a. Use in precautionary situations.
   b. Impaired sensitivity or ischemia.
   c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sore.

7. Hydrotherapy

   a. Facilitate assistive or resistive exercise.
   b. Removal of exudated or necrotic tissue.
   c. Reduce muscle spasm or pain.

   Indication for Denial

   a. General heat precautions.
   b. Treatment exposure using > 37 degrees centigrade in vascular impaired site.
   c. Absence of untoward effects or stable temperature tolerance and can be done by nursing staff.

8. Iontophoresis

   a. Antibiotic institution to avascular tissue.
   b. Medication for persistent post—surgical incision pain.
   c. Reduce inflammation or edema of musculosketetal (joints).

   Indication for Denial

   a. Anesthetic use (injection faster).
   b. Response lacking after reasonable interval.

3. Low—Energy Laser

   a. Wound tissue healing.
   b. Pain management over trigger points.

   Indication for Denial

   a. Investigational.
   b. Effectiveness in rheumatoid arthritis questioned.

4. Transcutaneous Electric Nerve Stimulation (TENS)

   a. Post—operative incisional pain.
   b. Orthopedic analgesia acute or chronic, application to either trigger point or peripheral nerve.
   c. Chronic low back pain.
   d. Osteogenesis.
   e. Reflex sympathetic dystrophy (RSD).

   Indication for Denial

   a. Chronic radiculopathy pain.
   b. Cognitively impaired or unwilling to participate with schedule and safety factors.
   c. Unsafe application.
   d. Nursing is capable of managing (or resident can set—up, apply or control) after the initial evaluation of response or control setting is achieved.

5. Heat Therapy

   a. Active treatment of musculoskeletal mobility or pain problem as part of a therapist—driven treatment plan.
   b. In conjunction with an exercise regimen.

   Indication for Denial

   a. The active disorder is controlled, mostly for comfort.
   b. Complexity manageable by nursing.
   c. Resident is not responsive or is non-communicative.
   d. Ischemic limbs or other site or atrophic skin.

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Physical Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

a. When exercising muscle or joint structure, the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
b. Progress is shown at predictable intervals.
c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

a. Lacks documented detail of dysfunction or goal.
b. Goal seems unreasonable.
c. Stability of resident questioned.
d. Participation level a hindrance.
e. Plateaued, goal achieved, or needs only repetitive range of motion for nursing care plan.
f. Persistent flaccidity > 2—4 weeks in the focused area.

2. Cold Therapy

a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
b. Trigger point use myofascial pain syndrome.
c. Spasticity.

Indication for Denial

a. Response gain is not demonstrable.
b. Performance is at nursing instructed level, and labile complex features.
c. Inappropriate use in a vascular compromised setting (or labile or poor blood pressure control).
d. Cold sensitivity disorder.

Technical Criteria for Reviewing Ancillary Services for Adults

February 2000 Edition

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

MAP-248
(Rev. 12/01)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name_____Provider # _____

Agency Address_____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name_____MAID #_____

Address_____ Medicare #_____

_____ Birthdate_____

Other Insurance_____

Diagnosis_____

_____

_____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

(Indicate Directions for Use of the Supplies)_____

_____

_____

_____

_____

Anticipated Duration of Need:_____1-30 Days _____1-6 Months _____Lifetime _____Indefinite

I,_____ certify this patient requires the supplies listed above.
Physician's Signature

Address_____ License #_____Date_____

_____

Must be signed and dated by the physician every 6 months.

13. Transdermal Antihypertensive Medication

Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient shall remain the provider during the period of the pre-authorization unless a valid reason for change exists.

E. PreAuthorization Period

The maximum period for which any drug shall be preauthorized shall be six (6) months. A request for renewal shall be considered if the need for the drug continues to exist. Extensions may be backdated if the dates do not interfere with already existing segments on the drug file.

F. Minimum Cost Requirement

Only those requests for oral, non-liquid drugs which cost $5.00 or more to the pharmacy for a month's supply or a course of treatment shall be considered for pre-authorization.

G. Routine Immunizations

Immunizations requested for routine health care shall not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.

H. Exceptions to Existing Policy

The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.

6. Hypnotics and Sedatives

Requests for sedatives and hypnotics shall be considered only after covered antidepressant or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also these requests shall be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives shall not be approved for more than two (2) weeks, unless there is a diagnosis of terminal cancer.

7. Maintenance-Type Drugs

Requests for maintenance-type drugs shall be considered only if the drugs have been tried for at least two (2) weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

8. Non-Legend Drugs

Non-legend (over-the-counter) drugs shall be excluded from coverage under drug pre-authorization.

The only exceptions shall be non-legend nutritional supplements as noted in I. A. 2. above and nicotinic acid.

9. Ophthalmics and Topical Preparations

Requests for ophthalmics or topical preparations shall not be preauthorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

10. Tranquilizers, Minor

Requests for minor tranquilizers shall be considered only for acute anxiety, alcohol or drug withdrawal (with a one (1) month limitation), cancer, seizure disorders, and quadriplegia/ paraplegia.

11. Ulcer Treatment Drugs, Legend

On the basis of ulcer symptoms, legend ulcer treatment drugs may be preauthorized if other applicable pre-authorization criteria are met.

12 Total Parenteral Nutrition

May be preauthorized if the need exists.

6. The Program shall not preauthorize the trial usage of a maintenance drug except when the drug has been tried for at least two (2) weeks with successful results prior to the request. In these cases, when all criteria shall be met, retroactive pre-authorization for two (2) weeks shall be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines shall be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics shall be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six (6) months. A seven (7) day approval may be made following out-patient surgery.

2. Antibiotics

Requests for antibiotics shall be considered ONLY if culture and sensitivity tests have identified specific sensitivity or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration shall be given to the request.

3. Anti-Inflammatory Drugs (NSAID's)

Request for anti-flammatory drugs shall not be pre-authorized unless drugs on the Drug List or NSAID certification list have been tried unsuccessfully.

4. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Request for "cough mixture" preparations such as expectorants and antitussives shall not be pre-authorized. Only specified antihistamines may be preauthorized if all other criteria have been met.

5. Chemotherapeutic Agents

Request for anti-neoplastic agents shall be considered for approved FDA indications.

(Revised 1/92)

DEPARTMENT FOR MEDICAID SERVICES
DRUG PRE-AUTHORIZATION POLICIES AND PROCEDURES

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure shall be to provide Department for Medicaid Services (DMS) recipients with access to certain legend drugs not normally covered on the DMS Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. The requests shall be referred to the Program by physicians, pharmacists, and social workers. Determinations shall be made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which shall be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drugs shall be used in lieu of hospitalization to maintain the patient on an outpatient basis or prevent a higher level of care.

2. The requested drug shall be a legend drug. The only exception shall be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition shall be maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.

3. The requested drug shall be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).

4. The requested drug shall not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective" or if the labeler has not signed a rebate agreement with the Health Care Financing Administration (HCFA).

5. Drugs on the formulary shall be tried, when appropriate, with documentation of ineffectiveness prior to pre-authorization.

MAIL TO: EDS FEDERAL CORPORATION
P. O. BOX 2009
FRANKFORT, KY 40602

APPENDIX XI

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)

EDS FEDERAL USE ONLY

2. Recipient Name

3. Recipient Medicaid Number

4. Provider Name/Number/Address

5. From Date Service

6. To Date Service

7. Billed Amt.

8. Paid Amt.

9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY--DO NOT WRITE BELOW THIS LINE

ield/Line:

lew Data:

revious Data:

ield/Line:

ew Data:

evious Data:

h. Actions/Remarks:

f. Cognition.

Indication for Denial

a. The condition prevents the individual from engaging in the technique or use of the device.
b. Technique is reached, resident or nursing staff can maintain activities for endurance, distance or repetition.
c. Chronic condition, therefore potential useful gain is questioned or minimal.
d. Unable to advance or use more complex dexterity level due to cognitive limits..
e. Biofeedback use in the presence of a prominent disorder. speech, language use, cognition or volitional ability (inability to follow festural or verbal instruction.
f. Coma stimulation - effectiveness questionable

III. SPEECH THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process will employ the preferred practice patterns developed by the American Speech—Language—Hearing Association.

B. Deficiency of function must be of a significant level that an ancillary clinician s expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Treatment of Dysphagia (swallowing) Disorders

a. Applicable diagnostic tests with confirmed abnormality (initial or progress recheck).
b. Active teaching is appropriate for cognitive level (vs. delay till progress gain and provides alternative nutrition source).
c. Uses specific postural, reflex facilitation, food placement, modified diet techniques with demonstrable progress.
d. Prosthetic use.

Indication for Denial

a. Plateau, learned response, and repetitive exercise, reminders or prosthetics can be done by nursing as effectively.
b. Confirmatory diagnostic test unavailable.
c. Resident uncooperative or unreliable to safely use needed techniques.

2. Speech and Cognitive Disorders

a. Tentative projected rehabilitation gain at the stage when cognitive level permits measurable change.
b. Participation by resident required for repetitive or grouped exercises.
c. Prosthetic training.
d. Demonstrates there is no contributing significant auditory impairment.
e. Use of nursing facility environment or staff to assist goals.

Indication for Denial

a. Inability to participate.
b. Plateau is reached in functional gain by measurable data or learned exercise and nursing can do repetitive technique.
c. Effectiveness of modality or participation level is in question.
d. Persisting active program beyond gain in condition having progressive deteriorating change or outlook (bilateral cerebral vascular accident, alzheimers).
e. Oral—nonverbal apraxia beyond 2 months.
f. Accompanying peripheral vision or hearing defects.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. **STANDARDS OF PRACTICE:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.

B. Technical abbreviations used in Item VII - Oxygen Therapy.
ABG - Areterial Blood Gases
AVF - Augmented Voltage Foot
O2 - Oxygen Level
paO2 - Partial Pressure of Oxygen
paCO2 - Partial Pressure of Carbon Dioxide
Oxygen Sats - Oxygen Saturation Levels
HCT - Hematocrit Level
mm Hg - Millimeters of Mercury

C. General Indicators.

1. Pa02 < 55 mm Hg or saturation < 88% while breathing ambient air.

2. Optimum medical management.

   a. Ancillary repiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.

3. PaO2 of 56-59 mm Hg or saturation of 91% in the presence of one or more of the following:

   a. Corpulmonale (p wave greater than 3 mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct > 56%).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dyspnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation while on 02 < 92%.
   b. Pa02 < 60 mm Hg.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABF or oxygen Sats or improved symptoms).

E. Noncontinuous Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" Pa02 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have available unless clinical documentation establishes hypoxemia and there exist circumstances why a person would not fit the category for continuous, exercise related, or sleep related.

F. Monitoring Condition

1. Acute use based on baseline Pa02/02 saturation and PaC02 in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changed and/or the resident's altered clinical condition in response to therapy.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent condition.
   c. Dependent upon the arterial parameters needed.
   d. Oximetry is useful for non-hypercapneic persons as a guide to oxygen dose initation. It is simpler for nursing to utilize or log data. It is essentially nontraumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with Pa02 drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable oxygen dependent condition. This is considered a reasonable interval to assess progress and establish continued need. More frequent may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia establish regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1—2 months; again with exacerbation of illness of changing perameters of function closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50% of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost effective as the nasal prong as it is not as enduring.

V. RESPIRATORY THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **Standards of Practice:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.

B. Technical abbreviations used in Item VIII — Respiratory Therapy.
FEVI — Forced Expired Volume after one second
FVC — Forced Vital Capacity
IPPB — Intermittent Positive Pressure Breathing
MDI — Metered Dose Inhalers
PFT — Pulmonary Function Tests

C. Indications.

1. Provide direct management of the following:

   a. Aerosolized drug delivery.
   b. Humidification.
   c. Secretion care management.
   d. Tracheostomy care.
   e. Osygenation changes (when possible in Conjunction with obtaining ABGs. or oximetry checks).

2. Teaching resident self treatment of the following:

   a. Aerosol.
   b. Breathing exercises.
   c. Cough guidelines.

3. Ongoing treatment requires the following:

   a. Specialty staff to assess response if new therapy.
   b. Specialty staff if respiratory therapy service is beyond usual nursing staff expertise (do the nurses provide the resident respiratory therapy on weekends when respiratory therapist is not available).
   c. If chronic clinical condition or nursing care plan therapy, documentation is necessary by the respiratory therapist and physician to support ongoing necessity of therapist versus nursing staff or resident administered therapy.

4. For a self administered system of therapy the following is required:

   a. Resident must demonstrate proper use of the equipment or medication delivery system.
   b. Resident delivery system monitored by nursing staff.
   c. Respiratory therapist intervention would be expected to drop when metered dose inhalers and nebulizers are utilized as resident or nursing staff can provide this therapy at the nursing care plan level.

5. The following situation may necessitate a respiratory therapist:

   a. Initial MDI or nebulization treatments may be performed by ancillary staff if no nursing staff is familiar with the mode of therapy. Should this occur, the ancillary respiratory therapist is responsible for providing instructions to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.

D. Aerosol Therapy.

1. Physician must order the medication utilized for the delivery system.

2. Mode of delivery or humidity needed may be determined by the respiratory therapist in the initial setting.

3. The simpler modalities are as effective and can be given in the absence of a respiratory therapist provided the facility staff are trained or comfortable or available to do this. Verify by physician order the acceptability of this process.

4. Metered dose inhalers (MDI) with or without spacers properly utilized were effective compared to nebulizers or IPPB (IPPB has been shown to be no more effective generally than MDI or nebulizers).

5. MDI should be attempted in bronchodilator therapy as simpler for nursing and residents to manage.

6. Nebulizer (compressed air driven apparatus) should be utilized when MDI is shown to be inadequate for the treatment of an individual clinical condition. It may also have to be utilized if a specific drug is not available via the MDI system.

7. Nebulizer therapy can be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. It can also be performed with safety by facility staff. The need for a respiratory therapist should be evident in charting. It is reasonable to utilize the respiratory therapist initially to verify resident response to nebulizer therapy but once considered stable or nursing care plan then the facility staff or resident should assume nebulizer therapy responsibility.

8. IPPB (intermittent positive pressure breathing) has principally been replaced by MDI or nebulizer therapy as the acceptable delivery system. It is no more effective than other equipment. If utilized documentation should exist why other simpler and potentially less complication associated mode care not utilized. This therapy would potentially require a respiratory therapist beyond the initial phase of administration.

9. The use of inhalers and bronchodilator therapies should always be supported by persistent symptoms, physical findings as well as PFT (Pulmonary Function Test). This information should be found in the respiratory therapist's notes. Usually documented is impairment of airway or lungs function and should be considered greater than "mild" dysfunction. Criteria for PFT which indicate moderate obstruction follow:

   a. FEV1 51—59% predicted.
   b. FEV1/FVC 41—59% predicted.
   c. Clinical evidence that there is a reversible component to support use of an aerosol bronchodilator.

10. The frequency of treatment (MDI or nebulizers) should be reasonable for the illness or clinical presentation. Generally, aerosolized bronchodilator are given at intervals that correspond to duration of effect of the drug or aerosol treatment. (Monitor significantly reduced PRN schedules as there could be question to the need for the drug in this form of delivery frequency).

E. Monitoring Therapy.

1. It is the physician's responsibility to assess the plan of treatment and document the resolution if short term therapy. In the event of a chronic diagnosis the physician must document the reasonable nature of ongoing therapy.

2. In the event of long term treatment the following information should be available:

   a. Annual Pulmonary Function Test (PFT) should be available.
   b. Peak flow rates—to serve as intermittent indicators to be determined by the attending physician or respiratory therapist.

3. Appropriateness of therapy should be questioned in the following situations:

   a. Chest physiotherapy or use of mucolytic aerosols when no secretions are evident after treatment course is "completed."
   b. Aerosol therapy for interstitial lung disease as primary diagnosis for treatment initiation.
   c. Aerosol therapy when irreversible airflow obstruction exists.

Technical Criteria for Reviewing Ancillary Services for Pediatrics

April 2000 Edition

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE- PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice by the American Physical Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain is documentable.

1. Therapeutic exercise/gross motor development program.

   a. Exercises are designed to utilize neuro developmental techniques, reflex integration, and perceptual-sensory motor integration to assist to reach the maximum potential possible. The Therapist's expertise is required to design, supervise or conduct a program in which there is a need for developmental or functional gain.
   b. Progress is demonstrated at predictable intervals.

   Indication for Denial

   a. Medically unstable.
   b. Goal seems unreasonable.
   c. Participation level questioned.
   d. Plateaued or achieved goals..
   e. Lacks documentation.

2. Chest Therapy-when respiratory therapy is not available.

   Postural drainage, including positioning to loosen secretions and promote drainage is within the training of the Physical Therapist. This is addressed with the bed fast, non-ambulatory or resident with pneumonia.

   Indication for Denial

   a. In-house Respiratory therapist.
   b. Managed by nursing/caregiver.
   c. Condition clinically stable and manageable by nursing/caregiver.

3. Equipment and/or orthopedic appliances assessed, fitted, adjusted and monitored. The pediatric resident utilizes equipment throughout his/her lifetime.

   a. Modify or monitor wheelchairs.
   b. Upon M.D. prescription, order, modify, monitor orthotic appliances. Work to train care givers and residents use of appliances. This includes, but is not limited to, braces, walkers, crutches, canes, oyster shells and back braces.

   Indication for Denial

   a. Unteachable.
   b. Repetitive use for distance or endurance.
   c. Resident can perform trained excersises.
   d. Nursing can monitor fit.
   e. Nursing can monitor maintenance of equipment of minor deficiencies/repairs.

4. Assessment to provide individualized, detailed documentation of the function of a particular child. This is generally performed at 6-12 month intervals or when change is indicated. Assessment may include, but is not limited to:

   a. Postural reflex integration.
   b. Status of sensory, motor, neuro motor and musculoskeletal systems.
   c. Perceptual motor development.
   d. Joint range of motion.
   e. Analysis of functional independence.
   f. Postural deviations.
   g. Gait analysis.
   h. Developmental level, including gross and fine motors.
   I. Adaptive equipment needs.
   j. Resident's and/or family needs.

   Indication for Denial

   a. Resident medically unstable.
   b. Lacks developmental maturation changes to justify reassessment.
   c. Lacks potential for gain.

generally found in these residents.

2. If a plateau has been indicated via documentation then one could consider transferring care to the facility staff for the uncomplicated, stable lung disorder. This could encompass the following care needs:

   a. Aerosal therapy.
   b. Routine trach care.
   c. Nursing care plan oxygen administration.

3. Nursing care plan service or plateau should be supported by documentation in the ongoing nursing assessment and the respiratory therapist's notes. The potential for changing to facility staff provided or supervised therapy administration or delivery systems exists if resident is stable or nursing care plan with chronic condition. This care provision change should be considered less complex, less costly and should not adversely affect the efficacy of the treatment.

apnea. PFT criteria is most applicable to adults and older, cooperative children. PFT criteria for continued therapy is not required for children who are unable to perform PFT accurately and who require continued therapy because of the continued respiratory problems.

(10) The frequency of treatment (MDI or nebulizers) should be reasonable for the illness or clinical presentation. Generally, aerosolized bronchodilator are given at intervals that correspond to duration of effect of the drug or aerosol treatment. (Monitor significantly reduced PRN schedules as there could be question to the need for the drug in this form of delivery frequency). Children, however, may have respiratory problems which are very episodic and presence of sporadically used respiratory treatments may often be appropriate treatment for short-lived, episodic, respiratory problems.

d. Monitoring Therapy.

1. It is the physician's responsibility to assess the plan of treatment and document the resolution if short term therapy. In the event of a chronic diagnosis the physician must document the reasonable nature of ongoing therapy.
2. In the event of long term treatment the following information should be available:

a. Annual Pulmonary Function Test (PFT) should be available.
b. Peak flow rates-to serve as intermittent indicators to be determined by the attending physician or respiratory therapist.
c. If accurate pulmonary function testing or peak flow rates are not possible because the pediatric patient is unable to perform them, documentation of the need for long term therapy can be made on the basis of the frequency of acute episodes during the previous year as described in the care record.

D. Respiratory staffing of neonatal and young children.

1. Older children or adolescents with pulmonary disorders amenable to active respiratory treatment will require the intervention and monitoring of a respiratory therapistin most situations. This is principally for the purspose of addressing changing oxygenation needs and secretions clearing problems

c. Aerosol Therapy.

(1) Physician must order the medication utilized for the delivery system.
(2) Mode of delivery or humidity needed may be determined by the respiratory therapist in the initial setting.
(3) The simpler modalities are as effective and can be given in the absence respiratory therapist provided the facility staff are trained and comfortable or available to do this. Verify by physician order the acceptability of this process.
(4) Metered does inhalers (MDI) with or without spacers properly utilized.
(5) MDI (if child is on dosage compatible) should be attempted in bronchodilatior therapy as simpler for nursing and residents to manage.
(6) Nebulizer (compressed air driven apparatus) should be utilized when MDI is shown to be inadequate for the treatment of an individual clinical condition. It may also have to be utilized if a specific drug is not available via the MDI system.
(7) Nebulizer therapy can be performed safely by facility staff. Nebulizer therapy can also be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. It is reasonable to utilize the respiratory therapist initially to verify resident reponse to nebulizer theapy but once considered stable or nursing care plan then the facility staff ro resident should assume nebulizer therapy responsibility.
(8) IPPB (intermittent positive pressure breathing) has principally been replaced by MDI or nebulizer therapy as the acceptable delivery system. It is no more effective than other equipment. If utilized documentation should exist why other simpler and potentially less complication associated mode care not utilized. This therapy would potentially required a respiratory therapist beyond the initial phase of administration.
(9) The use of inhalers and bronchodilator therapy should always be supported by persistent symptoms and physical findings as well as PFT (Pulmonary Function Test) if applicable. This information should be found in the respiratory therapist's notes. Usually documented is impairment of airway or lungs function and should be considered greater than "mild" dysfunction. Criteria based on PFTs is not usually feasible in the pediatric population due to the inability to follow commands for inspiration, expiration or sustained

3. Ongoing treatment requires the following:

   a. Specialty staff to assess response if new therapy.
   b. Specialty staff if respiratory therapy service is beyond usual nursing staff expertise (do the nurses provide the resident respiratory therapist on weekends when respiratory therapist is not available).
   c. If chronic clinical condition or nursing care plan therapy, documentation is necessary by the respiratory therapist and physician to support ongoing necessity of therapist versus nursing staff or resident administered therapy.

4. For self administered system of therapy the following is required:

   a. Resident must demonstrate proper use of the equipment or medication delivery system.
   b. Resident delivery system monitored by nursing staff.
   c. Respiratory therepaist intervention would be expected to drop when metered dose inhalers and nebulizers are utilized as resident or nursing staff can provide this therapy at the nursing care plan level.

5. The following situation may necessitate a respiratory therapist:

   a. Initial MDI or nebulization treatments may be performed by ancillary staff if no nursing staff is familiar with the mode of therapy. Should this occur, the ancillary respiratory therapist is responsible for providing instruction to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.
   b. If the pediatric patient has an acute or ongoing unstable pulmonary problem, including deterioration in status, complex respiratory care needs, frequent monitoring, weaning of modalities, complications of primary disease or therapies.

V. RESPIRATORY THERAPY: REVIEW FOR BILLING AS AN ANCILLARY PEDIATRICS

A. Standards of Practice. The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

B. Technical abbreviations used in Item VIII-Respiratory Therapy.
FEVI-Forced Expired Volume after one second
FVC-Forced Vital Capacity
IPPB- Intermittent Positive. Pressure Breathing
MDI- Metered Dose Inhalers
PFT-Pulmonary Function Tests

C. Indications.

1. Provide direct management of the following:

   a. Aersolized drug delivery.
   b. Humidificaiton.
   c. Secretion care management.
   d. Tracheostomy care.
   e. Oxygenation changes (when possible in conjunction with obtaining ABG's or oximetry checks).

2. Teaching resident self treatment of following:
   (In pediatric care patient education is dependent on age and severity of the physical and mental disabilities of the child):

   a. Aerosol.
   b. Breathing exercises.
   c. Cough guidelines.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent conditions.
   c. Dependent upon the arterial parameter needed.
   d. Oximetry is useful for non-hypercapnic persons as a guide to oxygen dose initiation. It is simpler for nursing to utilize or log data. It is essentially non-traumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with $PaCO_2$ drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable, oxygen dependent condition. This is considered a reasonable interval to assess progress and established continued need. More frequent testing may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia, the established regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1 to 2 months. With exacerbation or illness of changing perimeters of function, closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by the treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50 percent of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost-effective as the nasal prong as it is not as enduring.

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation <95% or PaO_2 <65 $_{mm}$ Hg while breathing oxygen. Monitor functional improvement resulting from oxygen therapy (e.g., oxygen saturation, PaO_2, symptomatic improvement.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABG or oxygen sats or improved symptoms).

E. Noncontinuos Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" PaO2 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have oxygen available unless clinical documentation establishes hypoxemia and there exist circumstances why the person would not fit the category for continuous oxygen or, exercise related or sleep related non-continuos oxygen. An exception is made for brittle pediatric residents who have a significantly decreased PaO_2 with feeding, communication, or crying.

F. Monitoring Condition

1. Acute use based on baseline PaO_2 or O_2 saturation and $PaCO_2$ in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changes or changes in the resident's clinical condition in response to therapy.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. Standards of Practice. The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

Technical abbreviations used in item IV-Oxygen Therapy:

1. ABG-Arterial Blood Gases;
2. AVF-Augmented Voltage Foot;
3. 02- Oxygen Level;
4. PaO_2 -Partial Pressure for Oxygen;
5. $PaCO_2$ -Partial Pressure of Carbon Dioxide;
6. Oxygen Sats-Oxygen saturation levels;
7. HCT-Hematocrit Level; and
8. mm Hg- Millimeters of Mercury

C. General Indicators

1. Oxygen saturation < 93% or PaO_2 <65 mm Hg while breathing room air.

2. Optimum medical management.

   a. Ancillary respiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.

3. PaO2 of 56-59 mm Hg or saturation of 91 percent in the presence of one or more of the following:

   a. Cor pulmonale (p wave greater than 3mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct >56 percent).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dysnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.)

1. Clinically relevant deficiencies.
2. Potential gain.
3. Demonstrable developmental maturation changes that require ancillary ST input.

Indication for Denial

a. Resident not able to participate medically.

Indication for Denial

a. Standardized and nonstandardized measures reveal age appropriate speech-language skills, utilizing AAC.
b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech-language evaluation.
c. Lack new equipment problem.
d. Nursing/caregiver can perform maintenance repair.
e. Lack of nursing/caregiver training.

4. Aural Habilitation/Rehabilitation.

a. Comprehension and production of language in oral, augmentative, signed or written modalities.
b. Speech and voice production.
c. Auditory training.
d. Speech reading.

Indication for Denial

a. Audiological assessment reveals adequate hearing acuity.
b. Standardized and nonstandardized measures reveal age appropriated speech-language and cognitive skills. U,
c. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech language evaluation.
d. Lack new equipment problem.
e. Nursing/caregiver can perform maintenancelrepair.
f. Lack of nursinglcaregiver training.

5. Consultation and care Giver Instruction

a. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming, taking into consideration:

2. Oral pharyngeal function (dysphagia) and related disorders.

   a. Applicable diagnostic testing with confirmed abnormality.
   b. The absence of, or restricted oral presentation of food and/or liquids.
   c. Strategies that alter behavior (e.g., posture, rate, learned airway protection measures, method of intake, prosthetic use, etc.)
   d. Modification of swallowing activity in coordination with respiratory or alternation of bolus characteristics (e.g. volume, consistency).
   e. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

   Indication for Denial

   a. Standardized tests, observations, instrumental diagnostic procedures, structural assessment and functional assessment reveal normal parameters of the swallow system and other oral pharyngeal functions.
   b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.
   c. Lack new equipment problem.
   d. Nursing/caregiver can perform maintenance/repair.
   e. Lack of nursing/caregiver training.

3. Augmentative and Alternative Communication (AAC) Systems.

   a. Training of prerequisite skills for AAC includes, but not limited to visual attention, visual tracking, choice making activities, cause and effect knowledge and anticipation of outcome.
   b. Determination of the MC intervention program (assessment).
   c. Selection and the development of an effective AAC system.
   d. Service implementation and system integration into the natural environment. Includes care-giver training.
   e. Follow-up and ongoing evaluation.
   f. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

III. SPEECH THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. Preferred practice patterns for professions of Speech-language Pathology and Audiology shall be those developed by the American Speech and Hearing Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain, or, as a preventative measure, is documentable.

1. Speech (articulation, fluency, voice), Language and Cognitive Disorders.

   a. Utilization of standardized testing measures.
   b. Treatment is conducted to achieve improved, altered, augmented, or compensated speech, language and cognitive communication behaviors or processes.
   c. Treatment may include prerequisite skill training which includes, but not limited to cooing, respiratory support for vocalization, oral stimulation, vocal turn taking, inflection, object permanence, cause and effect knowledge, problem-solving, gesturelsign.
   d. Prosthetic/adaptive device training (e.g. speaking valve, adaptive switch, adapted toys, etc.)
   e. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

Indication for Denial

a. Standardized and nonstandardized measures reveal age appropriate speech-language and cognitive skills.
b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.

Indication of Denial

a. Condition prevents engaging techniques or use of device.
b. Technique learned, resident or nursing staff can carry-out routinely.
c. Chronic condition limits functional gain-documentation shows failure of prescribed technique over reasonable time span.
d. Unable to advance or use more complex dexterity level due to cognitive limits-documentation shows failure of compensatory strategies over reasonable time span.

3. Splinting and fabrication/prescription for adaptive equipment/environments.

a. Fabrication and fitting of splints and adaptive devices restore function in neuromuscular and/or motor performance components to support highest practicable level of function as part of intervention plan.
b. Therapist shall document prescribed use of splints or devices and instruct caregiver
c. Therapist shall monitor, fit and repair splint or device and periodically make necessary modifications for fit, safety and changes in function.
d. Design of adaptive equipment and environment to improve function in performance areas and specified performance components that requires expertise of an ancillary clinician. Include safety devices and restraint alternatives in keeping with OBRA guidelines for restraint free environments.

Indication for Denial

a. Documentation does not support need.
b. Use of splint/device/environment incorporated into routine and nursing care plan (re-evaluation and modification by Occupational Therapist are allowable when changes in function occur.)

4. Consultation and Care-Givers Instruction
Consultation with care-givers shall be provided to establish consistency with nursing care plan and to prepare for discharge.

a. Clinically relevant deficiencies are present.
b. Potential gain is evident
c. The resident demonstrates developmental maturation changes that need ancillary OT input.

Indication of Denial

a. Lacks documented details of dysfunction or goal.
b. Stability of resident questioned.
c. Participation level a hindrance.
d. Unreasonable goal.
e. Plateaued, goal achieved, or needs only repetitive ROM, ADL coaching, or ustimulationn environment as by nursing care plan.
f. Adaptive equipment lacks usable functionality.
g. Nursing/caregiver can provide preventativelcompensatory techniques for ongoing application.

2. Activities of Daily Living

a. Grooming.
b. Oral Hygiene.
c. Toilet Hygiene.
d. Dressing.
e. Feeding and eating.
f. Medication routine.
g. Socialization.
h. Functional mobility

Highest level of function shall be consistent with developmental levels. Prerequisite' skills in identified performance areas shall be targeted and progress documented, including use of compensatory strategies and adaptive equipment When a plateau is reached, periodic re-evaluation are allowed and the ancillary clinician may resume treatment program if resident shows documented changes in function in performance area and performance components. Updating and progressing the activities of daily living program requires the expertise of the ancillary clinician and periodic program update with care-giver instruction are allowable.

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting the program in the presence of potential gain is. documentable. Uniform terminology of Occupational Therapy developed by the American Occupational Therapy Association shall be used to define deficiency of function.

1. Therapeutic activities shall address appropriate Occupational Therapy performance areas of:

   Activities of daily living.
   Work activities.
   Play or leisure activities.

   Treatment in each performance area shall address specific performance components. These performance components consist of

   Sensory Motor Skills.
   Cognitive Skills.
   Psychological Skills.

   (Please refer to attached copy of uniform terminblogy for Occupational Therapy definitions of performance areas and performance components.)

   a. Implementation of therapeutic activities requires a therapists' expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
   b. Progress is shown at predictable interval for remediation of dysfunction where appropriate.
   c. Compensatory and prevention intervention models are also utilized in treatment of individuals with chronic conditions and developmental disabilities. This may include adaptive equipment, technology, graded assistance, and task modification. Documentation of outcomes shall reflect progress in function in performance areas and performance components.

15. High Pressure Wound Irrigation.

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable efficacy of superiority to simpler devices.
    c. Nursing can provide equivalent service.

16. Hyperbaric Oxygen Wound Care.

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

13. Prosthesis.
    a. Resident has capacity to use device.
    b. Resident shows muscular strength, motor control, and range of motion adequate for gainful use.

Indication for Denial

    a. Unteachable
    b. Lacks above features.
    c. Poor wound healing.
    d. Other inappropriate conditions (such as bilateral above knee amputation over age of 45, or below elbow amputee and flail shoulder or elbow).
    e. Repetitive exercises, and/or use of pre-prothesis stump shinker prior to prosthetic fitting can be carried as part of the nursing care plan.
    f. Repetitive use for distance or endurance only and level change has been achieved.
    g. Assisting routine care of equipment.
    h. Resident can perform trained exercises with supervision by nursing.

14. Electromyographic Biofeedback.

    a. Spasticity or weakness as part of acute cerebral vascular accident (CVA).
    b. Acute or chronic spinal cord injury.
    c. Multiple sclerosis with mild spasticity.

Indication for Denial

    a. Absence of reasonable gain in treatment plan time frame.
    b. Conditions of questionable effectiveness.
    c. Resident lacks voluntary control or motivation.

10. Ultrasound.

    a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e. post-hip open reduction internal fixation.
    b. Reduce pain or muscle spasms.
    c. Trigger points.

    Indication for Denial

    a. Use in precautionary situations.
    b. Impaired sensitivity or ischemia.
    c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sores.

11. Hydrotherapy.

    a. Facilitate assistive or resistive exercise.
    b. Removal exudate or necrotic tissue.
    c. Reduce muscle spasm or pain.

    Indication for Denial

    a. General heat precautions.
    b. Treatment exposure using >37 degrees centigrade vascular impaired site.
    c. Absence untoward effects or stable temperature tolerance and can be done by nursing staff.

12. Iontophoresis

    a. Antibiotic institution to avascular tissue.
    b. Medication for persistent post-surgical incision pain.
    c. Reduce inflammation or edema musculoskeletal (joints).

    Indication for Denial

    a. Anesthetic use (injection faster).
    b. Response lacking reasonable interval.

7. Low-Energy Laser.

    a. Wound tissue healing.
    b. Pain management over trigger points.

    Indication for Denial

    a. Investigational.
    b. Efficacy in rheumatoid arthritis questioned.

8. Transcutaneous Electric Nerve Stimulation (TENS).

    a. Post-operative incisional pain.
    b. Orthopedic analgesia acute or chronic, apply to either trigger point or peripheral nerve.
    c. Low back pain chronic.
    d. Osteogenesis.
    e. Reflex sympathetic dystrophy (RSD).

    Indication for Denial

    a. Chronic radiculopathy pain.
    b. Cognitively impaired or unwilling to participate, with schedule and safety factors.
    c. Unsafe application.
    d. Nursing capable of managing (or resident can set-up, apply or control) after initial evaluation of response or control setting achieve.

9. Heat Therapy.

    a. Treatment actively of musculoskeletal mobility or pain problems as part of a therapist-driven treatment plan.
    b. In conjunction with exercise regimen.

    Indication for Denial

    a. Active disorder controlled, mostly comfort.
    b. Complexity manageable by nursing.
    c. Resident not responsive or non-communicable.
    d. Ischemic limbs or other site or atrophic skin.

5. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming. This could include, but not limited to instruction for:

   a. Application of orthopedic appliances.
   b. Use of adaptive equipment
   c. Positioning.
   d. Routine exercises.
   e. Routine gait training.

   Indication for Denial

   a. Resident not able to participate medically.
   b. Lacks changes (regression or improvement) to justify consultation.
   c. Lacks potential for gain.
   d. Nursing/caregiver can provide modification.

6. Cold Therapy

   a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
   b. Trigger point use myofascial pain syndrome.
   c. Spasticity.

   Indication for Denial

   a. Response gain is not demonstrable.
   b. Performance at nursing care plan level-routine program with no complex features.
   c. Inappropriate use in vascular compromised setting (or labile or poor blood pressure control).
   d. Cold sensitivity disorder.